DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners
- Emergency Physicians
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Organizations
- Nurse Anesthetists
- Ophthalmologists
- Physicians
- Physician Clinics
- Podiatrists
- Psychiatrists
- Radiologists
- Registered Nurse First Assistants

Memorandum No: 06-56
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For Information Call:
800.562.3022

From: Douglas Porter, Assistant Secretary
Health and Recovery Services Administration (HRSA)

Subject: Physician-Related Services: Corrections and Fee Schedule Updates

Effective for dates of service on and after July 1, 2006, the Health and Recovery Services Administration (HRSA) will implement:

- The updated Medicare Physician Fee Schedule Database (MPFSDB) Year 2006 Relative Value Units (RVUs);
- The updated Year 2006 Relative Value Guide base anesthesia units (BAUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The updated Medicare Average Sale Price (ASP) drug files;
- A legislatively appropriated one percent (1%) vendor rate increase; and
- The technical changes listed in this numbered memorandum.

Maximum Allowable Fees

HRSA updated the fee schedule with the Year 2006 RVUs, BAUs, clinical laboratory fees and Medicare ASP pricing. The 2006 legislature appropriated a one percent (1%) vendor rate increase for the 2007 fiscal year. HRSA adjusted the maximum allowable fees to reflect these updates.

Visit HRSA's website at http://maa.dshs.wa.gov. To view a current fee schedule, click ***Provider Publications/Fee Schedules***, then ***Accept***, then ***Fee Schedules***.

Conversion Factors

Below are HRSA's July 1, 2006 conversion factors:

Title	Procedure Codes	July 1, 2006 Conversion Factor
Adult Primary Health Care	99201-99215	$25.51
Anesthesia		20.99
Children's Primary Health Care	99201-99215, 99431-99435, and 99381-99395	35.00
Clinical Lab Multiplication Factor		.820
Maternity	59000, 59025, 59400-59410, 59425-59426, 59430, 59510-59525, and 59610-59622	44.71
All Other Procedure Codes (Except Clinical Laboratory)		22.93

Detoxification Services

HRSA covers detoxification services for clients receiving alcohol and/or drug detoxification services in an HRSA-enrolled hospital-based detoxification center or in an acute care hospital when the following conditions are met:

- The stay meets the intensity of service and severity of illness standards necessary to qualify for an inpatient hospital stay;
- The care is provided in a medical unit;
- The client is not participating in HRSA's Chemical-Using Pregnant (CUP) Women program;
- Inpatient psychiatric care is not medically necessary, and an approval from the Regional Support Network (RSN) is not appropriate; and
- Non-hospital based detoxification is not medically appropriate.

When the above conditions are met, providers must bill as follows:

Procedure Code-Modifier	Brief Description	Limitations
H0009	Alcohol and/or drug services [*bill for the initial admission*]	Limited to one per hospitalization. Restricted to ICD-9-CM diagnosis codes 292.0-292.9, 303.00-305.03, 305.20-305.93, and 790.3
H0009-TS	Alcohol and/or drug services with follow-up service modifier [*bill for any follow-up days*]	

Note: Bill HRSA directly for clients enrolled in an HRSA managed care plan for only those clients receiving detoxification services provided in a hospital that has a detoxification specific provider number.

Cardiac Rehabilitation

HRSA pays for cardiac rehabilitation (CPT code 93798) with continuous ECG monitoring only when billed with diagnosis codes 410.0-410.9, 413.0-413.9, V45.81, or V45.82. See Section G for coverage criteria.

HRSA limits code 93798 to 24 visits per incident. HRSA only pays for code 93978 when billed with place-of-service 21 or 22.

Clozaril Case Management

- Providers must bill for Clozaril case management using CPT code 90862 (pharmacologic management).

- HRSA does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

Code Updates

Effective for dates of service on and after July 1, 2006, HRSA made the following changes:

- The following procedure codes are **not covered**:

Procedure Code	Brief Description
36468	Injection(s), spider veins
36469	Injection(s), spider veins
36470	Injection therapy of vein
36471	Injection therapy of veins

- The following procedures codes **are covered**:

Procedure Code	Brief Description
95971	Analyze neurostim, simple
95972	Analyze neurostim, complex
95973	Analyze neurostim, complex

- The following additional procedures codes **require prior authorization (PA)**:

Procedure Code	Brief Description
L3170	Foot, plastic, silicone or equal, heel stabilizer, each
21198	Reconstr lwr jaw segment
29877	Knee arthroscopy/surgery
42145	Repair palate, pharynx/lesion
63650	Implant neuroelectrodes
63660	Implant neuroelectrodes
63685	Insrt/redo spine n generator
63688	Revise/remove neuroreceiver
76499	Radiographic procedure
96118	Neuropsych tst by psych/phys

- The following procedures codes **no longer require PA**:

Procedure Code	Brief Description
L3230	Custom shoe depth inlay

- The following procedures codes are now bundled:

Procedure Code	Brief Description
90887	Consultation with family
99091	Collect/review data from pt

Dental Preoperative Visits

HRSA covers one pre-operative Evaluation and Management (E&M) procedure by a physician for a dental client **prior to performing dental surgery** in an outpatient setting. You must bill using dental diagnosis codes 520.1–525.9 as the primary diagnosis when billing E&M codes for pre-op services for dental surgery, along with the appropriate pre op diagnosis codes V72.81–V72.84) as the secondary diagnosis. For clients assigned to an HRSA managed care organization, bill HRSA directly for history and physical claims for dental surgery.

If you bill emergency room visits or office calls in combinations with laboratory, x-ray, or ancillary services, bill with diagnosis codes V72.81-V72.84 in the second diagnosis field. If one of these diagnoses is not in the second diagnosis field, HRSA pays the E&M, but denies the laboratory, x-ray, or ancillary services.

Diabetic Education

HRSA continues to develop billing instructions for the Diabetic Education Program. Until those billing instructions are completed, HRSA has added billing information into the *Physician-Related Services Billing Instructions* and the Diabetic Education Fee Schedule into the Appendix to the *Physician-Related Services Billing Instructions*.

EPSDT Updates (*Foster Care Children)*

DSHS updated the "other" column of the Medical ID Card by adding one of the following letters to indicate the child is in foster care:

- **D** (Division of Developmental Disabilities client in relative placement);
- **F** (Foster Care placement); or
- **R** (Relative placement).

HRSA pays providers an enhanced flat fee of $120.00 per EPSDT screening exam for foster care clients who receive their medical services through HRSA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

Effective for dates of service on and after July 1, 2006, if the Medical ID Card indicates one of the above letters, the provider may bill one of the above screening codes with modifier 21 to receive the enhanced rate.

HRSA pays providers for EPSDT screening exams for foster care clients without regard to the periodicity schedule when the screening exams are billed using modifier 21.

Genetic Testing

For laboratories billing for genetic testing, the provider ordering the genetic test must give the laboratory the following:

- A PA number for the laboratory test (if applicable); and
- The Correct CPT genetic testing modifier to indicate the purpose of the test.

Health Departments

HRSA no longer pays health departments for CPT code 99211 when an immunization is the only service provided. HRSA pays health departments for the appropriate immunization code and administration code. However, if the vaccine is available free-of-charge from DOH, HRSA pays for the administration fee **only** when the vaccine is billed with modifier SL.

Additional Monitoring Modifier for High-Risk Antepartum Care

HRSA changed the required modifier providers use when billing E&M codes for additional visits that exceed the normal antepartum guidelines to monitor high–risk conditions. Providers who bill for high-risk additional monitoring visits for pregnancy-related services must attach the following modifier to the additional visit codes. All other maternity-related services policies still apply:

Modifier	Description
UA	M/CAID CARE LEV 10 STATE DEF

Immunization Update

HRSA no longer covers the following vaccine code. Please bill the appropriate single vaccine:

Procedure Code	Brief Description
90748	Hep b/hib vaccine, im

Note: If an immunization is the only service provided you must only bill for the administration of the vaccine and the vaccine itself (if appropriate). You must not bill an E&M procedure unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M with modifier 25. If you bill an E&M on the same date of service as a vaccine administration without modifier 25, HRSA will deny the E&M service.

Retroactive to dates of service on and after January 1, 2006, CPT® code 90712 is no longer available through the Universal Vaccine Distribution program and the Federal Vaccines for Children program.

HRSA no longer uses shading to identify vaccines that are free from the Department of Health (DOH). These vaccines are now identified as "free from DOH" in the "Comments" column of the Fee Schedule as "free from DOH."

Effective July 1, 2006, HRSA pays $5.96 for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).

Injectable Drug Updates

HRSA updates the maximum allowable fees for injectable drugs on a quarterly basis. Current and past fee schedules are posted on HRSA's website at http://maa.dshs.wa.gov. Click ***Provider Publications/Fee Schedules***, then ***Accept***, then ***Fee Schedules***. All fees have been updated at 106% of the average Sales Price (ASP) as defined by Medicare. If a Medicare fee is unavailable for a particular drug, HRSA prices the drug at 86% of the Average Wholesale Price (AWP).

Therapeutic and Diagnostic Injections

HRSA does not pay for CPT code 99211 billed on the same date of service as drug administration CPT codes 90760-90761, 90765-90768, or 90772-90779. If billed in combination, HRSA denies the E&M code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, HRSA will deny the E&M code.

Miscellaneous Updates

HRSA has updated the following sections of the *Physician-Related Services Billing Instructions*. These updated sections clarify medical and billing policies:

- "Hospital Inpatient and Observation Care Services" in Section B.
- "Detoxification Services" in Section B.
- "Reproductive Health Services" in Section H.
- "Enteral Nutrition" billing clarification in Section I.
- The diagnosis section for "Hyalgan/Synvisc" and "Injectable Drugs" in Section C.
- "Cancer Screens" policy clarification in Section E.
- Diagnosis updates in "Other Surgical Policies" in Section F.
- New codes and policy decisions were made in Section I, "Prior Authorization."
- HRSA clarified billing policies for RSNs and psychiatric services in Section E.

MRI/MRA, Hysterectomies, Bladder Repairs, Hospital Admits

HRSA no longer requires any form of authorization for MRIs/MRAs, hysterectomies, bladder repairs, or hospital admits.

Operating Microscope

HRSA follows CPT guidelines when paying for the use of the operating microscope. In addition, HRSA bundled the payment for use of the operating microscope into the following procedures when performed during the same operative session: 31530, 31535, 31540, 31560, and 31570.

PET Scans

HRSA no longer offers Expedited Prior Authorization (EPA) for PET Scans. All covered PET Scans require written or fax PA.

Physicians Providing Services to Hospice Clients

HRSA added a section in the *Physician-Related Services Billing Instructions* clarifying billing policies for physicians who provide services to hospice clients.

Place of Service

Reminder: Effective July 1, 2006, all claims submitted to HRSA must include the appropriate Medicare **two-digit place of service code.** Claims with a single-digit place of service code will be denied. See Numbered Memorandum 06-26 for previous notification of this change.

HRSA has added place of service 15 (mobile unit) to the non facility setting section.

Policy Corrections

On page B.1 of the *Physician-Related Services Billing Instructions*, HRSA has updated the "Programs (Guidelines/Limitations)" section regarding physical examinations for clients of the Division of Developmental Disabilities. The corrected paragraph now reads:

"One physical examination per client, per 12 months, for clients of the Division of Developmental Disabilities as identified on the DSHS Medical ID Card. Use HCPCS procedure code T1023 with modifier HI and ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for the examination."

Reminders

- When fee-for-service clients are admitted to a hospital and then become enrolled in an HRSA managed care organization, the entire hospital stay is paid fee-for-service until discharge. In order to be paid correctly for physician hospital visits, enter the following information on your HCFA-1500 claim form:

  - ✓ In field 18, enter the admission date to the hospital; and
  - ✓ In field 19 (comments field), enter "continuous hospital care."

- Provider enrollment has an updated phone number. Call: 800.562.3022 and choose option 3.
- Customer service for providers has an updated phone number. Call: 800.562.3022 and choose option 2.
- HRSA does not list those procedure codes that allow co-surgery or team surgeons, as these services are based on medical efficacy on a case-by-case basis.

Surgical Treatment for Sleep Apnea

HRSA requires PA for surgical treatment for obstructive sleep apnea (OSA) or upper airway resistance syndrome (UARS). HRSA requires PA for the following procedure codes when billed with diagnosis code 327.23 (obstructive sleep apnea) or 780.57 (unspecified sleep apnea):

- 21199;
- 21685;
- 42120;
- 42140;
- 42145;
- 42160; or
- 42299.

HRSA-approved Sleep Study Centers of Excellence

HRSA updated the medical policy and the list of payable ICD-9-CM diagnoses and has changed the billing procedures for Sleep Centers of Excellence. Enter the HRSA provider number of the approved sleep center where the sleep study/polysomnogram or multiple sleep latency testing was performed. Enter the HRSA approved sleep center of excellence provider number in the *Comment* section of the claim form or in box 32 of the HCFA-1500 paper claim.

Telehealth

HRSA pays for the following services through the Telehealth program:

- Consultations (CPT codes 99241-99255);
- Office or other outpatient visits (CPT codes 99201-99215);
- Psychiatric intake and assessment (CPT code 90801);
- Individual psychotherapy (CPT 90804-90809); and
- Pharmacologic management (90862).

Vision Services Update

HRSA allows bifocal eyeglass lenses to be replaced with single vision or trifocal lenses, or trifocal lenses to be replaced with single vision or bifocal lenses, when all of the following apply:

- A client has attempted to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustment; and
- The bifocal or trifocal lenses being replaced are returned to the provider.

New Billing Instructions

HRSA developed new *Physician-Related Services Billing Instructions*. See "How can I get HRSA's provider documents?" for information on obtaining these new billing instructions.

National Correct Coding Initiative

HRSA continues to implement the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists HRSA to control improper coding that may lead to inappropriate payment. HRSA bases coding policies on:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- The analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

HRSA may perform a post-pay review on any claim to ensure compliance with NCCI. Visit the NCCI on the web at http://www.cms.hhs.gov/physicians/cciedits.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain HRSA's provider numbered memoranda and billing instructions, go to HRSA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** **link**).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Health and Recovery Services Administration*.**

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Document Correction***. You will then need to select a year and the select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Orders may take up to 2 weeks to fill.)